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TO: **Arkansas Medicaid Health Care Provider – Children's Services Targeted Case Management**

DATE: **January 1, 2005**

SUBJECT: **Proposed Provider Manual Update Transmittal No. 5**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
Table of Contents	10-13-03	Table of Contents	1-1-05
200.000 – 215.200	10-13-03	200.000 – 215.200	1-1-05
240.000 – 250.100	10-13-03	240.000 – 250.100	1-1-05
260.000 – 262.100	10-13-03	260.000 – 262.100	1-1-05
262.300 – 262.310	10-13-03	262.300 – 262.310	1-1-05

Explanation of Updates

Sections 200.000 through 215.200, 240.000 through 250.100, 260.000 through 262.100 and 262.300 through 262.310 have been revised to reflect the program name change from Children's Medical Services Targeted Case Management to Children's Services Targeted Case Management.

In addition, the table included in section 262.100 has been corrected to include a second modifier used when billing for services and the inclusion of the type of service (TOS) code for ease of billing. The local code Z1934 has been removed as it is no longer a payable code, either for electronic or paper billing.

For your convenience, the entire Section II is attached to this transmittal memo. Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

SECTION II CHILDREN'S SERVICES TARGETED CASE MANAGEMENT CONTENTS

200.000 CHILDREN'S SERVICES TARGETED CASE MANAGEMENT GENERAL INFORMATION 1-1-05

201.000 Arkansas Medicaid Participation Requirements for Children's Services Targeted Case Management (TCM) Program 1-1-05

The provider of targeted case management for Children's Services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

A. The Children's Services targeted case management (TCM) provider must complete a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (form W-9) with the Arkansas Medicaid Program. **View or print a provider application (DMS-652), a Medicaid contract (DMS-653) and a Request for Taxpayer Identification Number and Certification (W-9).**

B. The provider application (DMS-652) and Medicaid contract (DMS-653) must be approved by the Arkansas Medicaid Program.

C. The Children's Services targeted case management staff must be licensed or certified in accordance with the requirements in Section 201.100 to serve their respective target population.

201.100 Qualifications of Children's Services TCM Provider 1-1-05

Providers of Children's Services targeted case management services must be certified and have a demonstrated capacity to provide all core elements of case management, which includes:

A. Assessment

B. Care or service plan

C. Development

D. Linking or coordination of services

E. Reassessment

F. Follow-up of services

The case management staff for targeted case management for Children's Services may include registered nurses, licensed social workers, pediatricians, registered dieticians, parent aides and clerical support staff who are credentialed or who are under the direct supervision of an appropriately credentialed case manager.

The qualifications for credentialed case manager include:

A. Registered Nurse
This individual must be licensed as a registered nurse by the Arkansas Board of Nursing and have satisfactorily completed a one-month (four-week) case management orientation provided by Children's Services.

B. Social Worker
This individual must be a licensed social worker in the State of Arkansas or be qualified through education, training or experience to work in a social work role and have satisfactorily completed a one-month (four-week) case management orientation provided by Children's Services.

C. Pediatrician
This individual must be a licensed M.D. in the State of Arkansas and have satisfactorily completed a one-month (four-week) case management orientation provided by Children's Services.

D. Parent Aide
This individual must be employed by Children's Services for the purpose of assisting families to access services and be a parent of a child with special health care needs. The parent aide must have satisfactorily completed the one-month (four-week) orientation provided by Children's Services. A parent aide cannot be a case manager of his or her own child.

E. Clerical Support Staff
This individual must have two years of experience with a program for children with special health care needs; experience with assisting families to obtain needed medical, social and educational services and must have demonstrated the ability to assist families appropriately to access needed services. The individual must have satisfactorily completed a two-week orientation training class with Children's Services.

202.000 Children's Services Targeted Case Management Providers in Bordering and Non-Bordering States 1-1-05

The Arkansas Medicaid Children's Services Targeted Case Management Program is limited to in-state providers only.

210.000 PROGRAM COVERAGE 1-1-05

210.100 Introduction 1-1-05

Children's Services serves as the Title V (Children with Special Health Care Needs) Agency within the single state agency, the Department of Human Services.

211.000 Scope 1-1-05

Medicaid-covered Children's Services targeted case management services are services that assist recipients in accessing needed medical, social and other support services appropriate to the recipient's needs.

Children's Services targeted case management services are covered when they are:

A. Medically necessary;

B. Provided to outpatients only;

C. Provided at the option of the recipient and by the provider chosen by the recipient;

D. Provided to recipients who have no reliable or available support to assist them in gaining access to needed care and services;

E. Services that directly affect the recipient but may not require the recipient's active participation (e.g., housing assistance) and

F. Furnished in accordance with a service plan.

212.000 Target Population Covered by Children's Services 1-1-05

Children's Services targeted case managers are restricted to serving recipients who are not receiving case management services under an approved waiver program, are not placed in an institution and are:

A. Aged 0 to 21 years and meet the medical eligibility criteria of Children's Services;

B. Recipients in the state's Title V Children with Special Health Care Needs Agency or

C. SSI/TEFRA Disabled Children Program recipients, aged 0 to 16 years, with any diagnosis.

213.000 Description of Service Activities 1-1-05

Children's Services must provide the following targeted case management activities.

A. Needs Assessment

1. A written comprehensive assessment (by Children's Services) of the child's needs, including analysis of recommendations (e.g., medical records) regarding the service needs of the child.

2. Review of records of medical/psychological evaluations in order to assess the child's needs.

3. Development of a service plan with the family.

4. Assisting the recipient in accessing needed services.

B. Service Plan

Monitoring the child's progress by making referrals to service providers through telephone, written or personal contacts; tracking the child's appointments; performing follow-up on services rendered and performing periodic reassessments of the child's changing needs (including reviews of the child's medical records).

C. Preparing and maintaining case records and documenting contacts, needed services, reports, and the child's progress, etc. These activities may apply to either the needs assessment or the service plan.

214.000 Exclusions 1-1-05

Services not appropriate for Children's Services targeted case management and not covered under the Arkansas Medicaid Program include, but are not limited to:

A. Targeted case management for recipients who are receiving case management services through the DDS Alternative Community Services Waiver Program.

B. The actual provision of services or treatment. Examples include, but are not limited to:

1. Training in daily living skills.

2. Training in work skills, social skills and/or exercise.

3. Training in housekeeping, laundry and cooking.

4. Transportation services.

5. Counseling or crisis intervention services.

C. Services that go beyond assisting individuals in gaining access to needed services. Examples include, but are not limited to:

1. Supervisory activities.

2. Paying bills and/or balancing the recipient's checkbook.

3. Observing a recipient receiving a service, e.g., physical therapy, speech therapy and classroom instruction.

4. Travel and/or waiting time.

D. Case management services that duplicate services provided by public agencies or private entities under another program authorized for the same purpose. For example, targeted case management services provided to foster children duplicate payments made to a public agency and are therefore not reimbursable.

E. Case management services that duplicate integral and inseparable parts of other Medicaid or Medicare services (for example, home health services) when provided on the same date of service.

F. Case management services provided to inpatients. Discharge planning is a required service of inpatient facilities. These facilities include, but are not limited to acute care hospitals, rehabilitative hospitals, inpatient psychiatric facilities, nursing homes and residential treatment facilities.

G. Case management services provided while transporting a recipient.

H. Time spent billing for targeted case management services.

I. Time spent determining medical and financial eligibility for Children's Services.

J. Any activity related to Children's Services authorization and payment of services.

215.000 Documentation Requirements 1-1-05

The Children's Services targeted case management providers must keep and properly maintain written records. At a minimum, the following records must be included in the provider's files.

215.100 General Records 1-1-05

General records that must be available for review include:

A. A copy of the Arkansas Medicaid contract (form DMS-653) for participation in the Arkansas Medicaid Program.

Copies of the Children's Services TCM staff's licensures and/or certifications.

215.200 Documentation in Recipient Files 1-1-05

The Children's Services targeted case manager must develop and maintain sufficient written documentation to support each service for which billing is made. All entries in a recipient's file must be signed and dated by the Children's Services targeted case manager who provided the service, along with the individual's title. The documentation must be kept in the recipient's case file.

Documentation should consist of, at a minimum, material that includes:

A. When applicable, a copy of the original and all updates of the recipient's individualized education plan (IEP) or individualized family service plan (IFSP).

B. The specific program services provided.

C. The date services are provided.

D. Updated progress notes describing the nature and extent of specific services provided. Progress notes are signed electronically.

E. The recipient's name and Medicaid identification number.

F. The name and title of the Children's Services targeted case manager providing the service.

G. A copy of the original and all updates of the Children's Services recipient's service plan.

215.300 Record Keeping Requirements 10-13-03

All records must be completed promptly, filed and retained for a period of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer.

All documentation must be made available, upon request, to authorized representatives of the Arkansas Division of Medical Services, the state Medicaid Fraud Control Unit, representatives of the Department of Health and Human Services and its authorized agents or officials.

At the time of an audit by the Division of Medical Services Medicaid Field Audit Unit, all documentation must be available at the provider's place of business during normal business hours. Requested documentation that is stored off-site must be made available to DMS personnel within three (3) business days.

If an audit determines that recoupment of Medicaid payments is necessary, DMS will accept additional documentation for only thirty days after the date of notification for recoupment. Additional documentation will not be accepted later.

Failure to furnish records upon request may result in sanctions being imposed.

240.000 PRIOR AUTHORIZATION 1-1-05

Prior authorization is not required for Children's Services targeted case management services.

250.000 REIMBURSEMENT 1-1-05

250.100 Method of Reimbursement 1-1-05

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the recipient and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying the recipient is eligible for Medicaid prior to rendering services.

Children's Services targeted case management services must be billed on a per unit basis. One case management unit is the sum of all Children's Services targeted case management activities that occur within a day.

251.000 Rate Appeal Process 10-13-03

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate.

Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference for a full explanation of the factors involved and the program decision.

Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

If the provider disagrees with the decision made by the Assistant Director, the provider may appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) management staff, who will serve as chairperson.

The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director of the Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the question(s) and will submit a recommendation to the Director of the Division of Medical Services.

260.000 BILLING PROCEDURES 1-1-05

261.000 Introduction To Billing 1-1-05

Children's Services targeted case management providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid recipients. Each claim may contain charges for only one recipient.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

262.000 CMS-1500 Billing Procedures 1-1-05

262.100 Children's Services Targeted Case Management Procedure Code 1-1-05

Providers of Children's Services targeted case management (TCM) must bill for services provided using the procedure code shown in the list below. Providers must use this code, along with the modifiers shown when billing either electronically or on paper for Children's Services TCM services. Additionally, when billing on paper, the procedure code must be billed with a type of service code "9".

National Code	Modifier 1	Modifier 2	Type of Service	Description	Benefit Limit
T1017	U2	22	9	Targeted case management, each 15 minutes (Children's Services targeted case management)	One (1) unit per client per day.

262.200 Place of Service and Type of Service Codes 10-13-03

Place of Service	Paper Claims	Electronic Claims	Type of Service (paper only)
Other locations	0	99	9 – Other Medical Service

262.300 Billing Instructions – Paper Only 1-1-05

EDS offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those which require attachments or manual pricing.

To bill for Children's Services targeted case management, use the CMS-1500. The numbered items correspond to numbered fields on the claim form. **View a CMS-1500 sample form.** The following instructions must be read and carefully adhered to, so that EDS can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to the EDS Claims Department. **View or print EDS Claims Department contact information.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

262.310 Completion of CMS-1500 Claim Form 1-1-05

Field Name and Number	Instructions for Completion
1. Type of Coverage	This field is not required for Medicaid.
1a. Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number.
2. Patient's Name	Enter the patient's last name and first name.
3. Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
Sex	Check "M" for male or "F" for female.
4. Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5. Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name, (post office box or RFD), city name, state name and zip code.
6. Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7. Insured's Address	Required if insured's address is different from the patient's address.
8. Patient Status	This field is not required for Medicaid.
9. Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
b. Other Insured's Date of Birth	This field is not required for Medicaid.
Sex	This field is not required for Medicaid.
c. Employer's Name or School Name	Enter the employer's name or school name.
d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10. Is Patient's Condition Related to:	
a. Employment	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."
b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two letter State postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
10d. Reserved for Local Use	This field is not required for Medicaid.
11. Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.

	a. Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer's Name or School Name	Enter the insured's employer's name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
	d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12.	Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13.	Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14.	Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15.	If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16.	Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17.	Name of Referring Physician or Other Source	Primary Care Physician (PCP) referral is not required for Children's Services TCM. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a.	I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18.	Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.
19.	Reserved for Local Use	Not applicable to Children's Services TCM.
20.	Outside Lab?	This field is not required for Medicaid.
21.	Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with CMS diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22.	Medicaid Resubmission Code	Reserved for future use.
	Original Ref No.	Reserved for future use.
23.	Prior Authorization Number	Enter the prior authorization number, if applicable.
24.	A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.

	B. Place of Service	Enter the appropriate place of service code. See Section 262.200 for codes.
	C. Type of Service	Enter the appropriate type of service code. See Section 262.200 for codes.
	D. Procedures, Services or Supplies	
	CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Section 262.100.
	Modifier	Use applicable modifier.
	E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only <u>one</u> diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
	F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
	G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
	H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
	I. EMG	Emergency - This field is not required for Medicaid.
	J. COB	Coordination of Benefit - This field is not required for Medicaid.
	K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."
25.	Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.

28.	Total Charge	Enter the total of Field 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. Do not enter any payment by the recipient, unless the recipient has an insurer that requires co-pay. In such a case, enter the sum of the insurer's payment and the recipient's co-pay. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE: For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
31.	Signature of Physician or Supplier, Including Degrees or Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and zip code of the facility where services were performed.
33.	Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
	PIN #	This field is not required for Medicaid.
	GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."

262.400 Special Billing Procedures 10-13-03

Not applicable to this program.